



ROCKVILLE HUMAN RESOURCES CENTER **EOD UN-PAID EMPLOYEE WORKSHEET**

[Please fax this completed document to 202-260-7032 or 202-401-2901]

PRINT NAME: LAST		FIRST	MIDDLE INITIAL	MAIDEN NAME:
ADDRESS (NUMBER, STREET NAME, ROUTE, P. O. BOX, APO/FPO)			APT #	DOB (mm/dd/yyyy)
CITY		STATE	ZIP CODE	SSN
CONTACT TELEPHONE NUMBERS: HOME / CELL (INCLUDING AREA CODES) <hr/> <hr/> <hr/>		EMERGENCY NOTIFICATION (NAME, ADDRESS, PHONE & RELATIONSHIP) <hr/> <hr/> <hr/>		
RACE & NATIONAL ORIGIN <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Hispanic <input type="checkbox"/> White, not of Hispanic Origin <input type="checkbox"/> Hispanic in Puerto Rico <input type="checkbox"/> Not Hispanic in Puerto Rico <input type="checkbox"/> I elect not to provide this information.				
HANDICAP: <input type="checkbox"/> I have a handicap. <input type="checkbox"/> I do not wish to identify my handicap status. <input type="checkbox"/> I do not have a handicap.				

I accept this appointment with the understanding that it is not to exceed 30 days, with the possibility of a 30 day extension. Under penalty of perjury, I declare that I have examined this form and to the best of my knowledge and belief, it is true and correct and complete.

Employee's Signature: _____ Print Name _____ Date: _____